PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 11/17/05

To: Staton

From: HCU

Inmate Name: Martin Moulton **ID#:** 225145

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Slide profile until MD appt

Start 11/17/05.

Date: 11/17/05 **MD Signature:** DePeasant/Smith PA **Time:** 1600

PHS/EMSA

PATIENT EDUCATION

ATHLETE'S FOOT

Athlete's foot is caused by a fungus. Fungus likes to grow in warm, moist places.

You should do the following things:

1. Keep your socks and shoes off whenever you can. Don't sleep with your socks on.

2. Wash your feet with warm, soapy water every day. . Dry between your toes. Dry your feet last to keep from spreading the fungus.

3. If you have shower shoes, wear them during the day.

5. Wear clean socks, (white cotton if you have them). Put clean socks on every day. Put your socks on before your underwear to keep the fungus from spreading.

6. Apply _____ cream to the athlete's foot area daily after you wash your feet. It does not take much cream and rub it in well. Wash your hands before and after you put the cream on.

If you don't get better after you do these things, return to sick call.

If your feet look like they are getting an infection:

Increased redness
Increased Swelling
Red Streaks
Pus Formation
Increased Pain

Return to sick call.

EVEN WHEN YOUR ATHLETE'S FOOT CLEARS UP, YOU SHOULD CONTINUE TO DO NUMBERS 1-5.

Inmate Name: Nelon Martin Date: 11-17-05

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 4/27/05

To: Staton

From: SHCU

Inmate Name: Martin, Marlon **ID#:** 225145

The following action is recommended for medical reasons:

1. House in
2. Medical Isolation
3. Work restrictions
4. May have extra _____ until _____
5. Other

Comments:

No prolonged standing > 10 minutes x 30 days

Date: 4/27/05 **MD Signature:** W. D. Williams MD **Time:** 5:30 pm

60418

PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, Marlon W Marlon Martin 225145 4-14-05
(Print Name) (Doc#)

acknowledge receipt of the following medical equipment or appliance:

( ) Splint
( ) Eyeglasses
( ) Dentures
( ) Prothesis describe _____
( ) Wheelchair
( ) Cane
(✓) Crutches
( ) Other describe _____

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

Marlon Martin 4-14-05
(Inmate) (Date)

Edward J Robinson 4-14-05
(Witness) (Date)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
Martin, Marlon	225145	12-17-78	B/M	Staton

PHS-MD-70005 (White – Medical File, Yellow – Security Property Officer)

PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, Martin, Marlon (Print Name) 225140 (Doc#)

acknowledge receipt of the following medical equipment or appliance:

( ) Splint
( ) Eyeglasses
( ) Dentures
( ) Prothesis describe _____
( ) Wheelchair
( ) Cane
( ) Crutches
(X) Other describe Knee Brace

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

Marlon Martin (Inmate) 4-5-05 (Date)

_____ (Witness) _____ (Date)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FA
Martin, Marlon	225140		B/M	Stat

PHS-MD-70005 (White – Medical File, Yellow – Security Property Officer)

PHS
PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Martin, Marlon

Date of Birth: 12/17/70 Social Security No.:

Date: 4/4/05 Time: 1700 A.M. P.M.

This is to certify that I, Martin, Marlon (Print Inmate's Name), currently in custody at the Staton (Print Facility's Name), am refusing to accept the following treatment/recommendations: no show for sick call (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

(Signature of Inmate)**

L Jones LPN (Signature of Medical Person)

(Witness)

Marie L Williams COT (Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

SCC

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 2/21/05

To: SCC

From: SHCU

Inmate Name: Martin, Marlon **ID#:** 225145

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

crutch profile x 10 days

Date: 2/21/05 **MD Signature:** M.D. [illegible] **Time:** 8:30pm

60418

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 3/21/05

To: Staton

From: HCU

Inmate Name: Marlon Martin **ID#:** 225145

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

No work on wet/slippery surfaces for 180 days

Date: _____ **MD Signature:** _____ **Time:** _____

60418

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 1/4/05

To: Staton

From: HCU

Inmate Name: Morgan Monty **ID#:** 225145

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

No prolonged standing >20 minutes
x 30 days expire 2/4/05

Date: _____ **MD Signature:** DMcCurdy **Time:** _____

60418

Prison Health Services
Treatment Record

Treatment Ordered:

DSG A - M, W, F (no duration given on # of days to be A'd)

Date	Date	Date	Date	Date	Date	Date
9.22	9.24	9.27	9.29	10.4	(10.11)	10.6
Tx Done	Tx Done	Tx Done	Tx Done	Tx Done		Tx Done
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Date	Date	Date	Date	Date	Date	Date
10.8						
Tx Done						
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Comments:

Patient Name/Number	Allergies:	Housing Unit:
225145 Martin, Marlon	NKA	ECC

PRISON HEALTH SERVICES INCORPORATED

FAX (334) 215-9126
Phone (334) 215-6678

Dee

Authorization for Release of Information

To: Baptist Med. Ctr. East

From: Kilby Prison
P.O. Box 11
Mt. Meigs, AL 36057

Patient: MARTIN, MARLON

Inmate ID No.: 225145

Alias:

Social Security No: 041-78-3610

Date of Birth: 12/7/70

Date(s) of Service: 9/04

I hereby authorize the above named provider to release to Prison Health Services, Inc. or any of its representatives the following confidential information:

[ ] ~~Physician/Provider's summary~~ of my diagnosis, medications, treatments, prognosis and recent care

[ ] ~~Admission~~ [ ] ~~Discharge~~ [ ] ~~Operative~~ Summary Reports

[ ] ~~X-Ray~~ [ ] Special Stucies Reports [ ] HIV Test [ ] T B Test

[ ] ~~Laboratory~~ Reports [ ] Immunization History [ ] Dental Treatment Records

[ ] Psychiatric Summary Report [ ] Substance Abuse Treatment History & Counseling Reports

[ ] Other Records _____
(Specify information requested)

This authorization shall remain in full force and effect until withdrawn in writing by me. I hereby release and agree to hold provider harmless from any and all liability that may result from such release of information.

Marlon Martin
(Patient's Signature) 9/20/04 (Date)

Annie P. Kimes
(Witness' Signature) 9/20/04 (Date)

The information requested is recognized as confidential and will be used only to ensure prompt and appropriate treatment of the named patient.

Charlotte Foster
(Signature and Title for PHS) 9/20/04 (Date)

P

Baptist Health
P.O. Box 244001
Montgomery, AL 36124

FACSIMILE

To: PHS

Company:

Fax: 215-9126

Date: 9-21-04

Total No. of pages: (Including Cover)

Re:

From: Casey

Company: Baptist East Medical Center

Tel: (334) 244-8471

Fax: (334) 244-8141

Comments:

0425900082 09/15/04 0 A M 12/17/70 33Y 2 EOS SUREOS / 252322

MARTIN,MARLON 041-78-3610
DRAPER CORRECTIONAL FACIL (334)567-2221
ELMORE
WETUMPKA AL 36092 NOT EMPLOYED

MARTIN,MARLON 12/17/70 33Y
DRAPER CORRECTIONAL FACIL 041-78-3610
(334)567-2221
WETUMPKA AL 36092 SELF NOT EMPLOYED

OTHER HMO OP MARTIN,MARLON 1

041783610 PRISON HEALTH SERVICES 225145

(334)395-5973

PO BOX 967 BRENTWOOD TN 370240967

ACL TEAR U

POLICE

2015 CHUNG,TAI Q 2015 CHUNG,TAI Q

11 09/15/04

ELECTIVE 1

EOPS

EE9 09/15/04 YES

PRINTED BY: b19310 DATE 9/21/2004

HISTPHYSS
BAPTIST HEALTH
2015
MARTIN, MARLON T
F0410600231
F000159871

PATIENT VERIFICATION DATA:
MARTIN, MARLON T- 0410600231

DATE OF PROCEDURE: 9/15/04

ADMISSION DIAGNOSIS:
1. Right knee tear of the anterior cruciate ligament.

HISTORY OF PRESENT ILLNESS The patient is a 33 year old gentleman who injured himself in September 2000. He has had continuing pain and giving way of the right knee. MRI scan showed a tear of the anterior cruciate ligament and edema at the posterolateral corner of the lateral tibial plateau. He is now admitted for arthroscopy, and right knee ACL reconstruction with tendon graft.

PAST MEDICAL HISTORY: No remarkable for any serious medical illness.

ALLERGIES: No known drug allergies.

MEDICINES: None

PHYSICAL EXAMINATION:
HEAD AND NECK: Normocephalic. Atraumatic. Extraocular muscles are intact. Pupils are equal round, reactive to light and accommodation.

LUNGS: Clear to auscultation.
HEART: S1, S2.
ABDOMEN: Bowel sounds are normal, soft non-tender.
NEURO: CNS 2-12 within normal limits. Motor and sensory are within normal limits.
MUSCULOSKELETAL: The right knee has minimal swelling. There is minimal tenderness along the joint lines. Range of motion is 0-110 degrees of flexion. Lachman's test is positive and anterior drawer sign is positive by 1/2 cm. Sensation good to light touch in the legs and foot. He can extend and flex the ankle and toes.

IMPRESSION:
1. ACL tear of right knee.

PLAN: To do ACL reconstruction with 1/3 patellar tendon graft Risks of surgery have been discussed with him including anesthesia, infection, neurovascular and tendon damage, incomplete return of full stability to the knee and incomplete return of function in the knee. He understands and wishes for surgery.

TAI Q. CHUNG, M.D.

D: 09/14/2004
(CONTINUED)D:09/16/2004
PRINTED BY: b19310 DATE 9/21/2004

Baptist Medical Center ... LABORATORY

Name: MARTIN, MARLON DOB: 12/17/1970

MR: E000252322 Acct: E0425900082

AdmPhys: Chung, Tia Q., MD

Admit date: 09/15/2004 Discharge date: 09/17/2004

HEMATOLOGY

Routine Hematology

COLLECTION DATE: 9/15/04
COLLECTION TIME: 8:38:00 AM

		REF RANGE	UNITS
WBC	3.6 L	[4.1-10.3]	Thou/mL
RBC	5.05	[4.69-6.13]	Mill/mL
Hemoglobin	15.2	[11.3-15.3]	gm/dl
Hematocrit	46.5	[40.0-51.0]	%
MCV	92	[81-100]	FL
MCH	30.1	[27.0-31.2]	pg
MCHC	32.7	[31.8-35.4]	gm/dl
Platelet Count i	217	[140-400]	Thou/mL
RDW	12.0	[11.5-14.5]	%

09/15/2004 08:38:00 AM Platelet Count:
Critical Ranges:
OB & Cardiac = <100,000
<90 days old = <100,000
All others = <50,000 >750,000

09/15/2004 08:38:00 AM ..CBC (Hemogram):
ROOM 113

Automated Differential

COLLECTION DATE: 9/15/04
COLLECTION TIME: 8:38:00 AM

		REF RANGE	UNITS
Neutro Auto	47	[40-75]	%
Lymph Auto	39	[20-53]	%
Mono Auto	10	[0-12]	%
Eos Auto	4	[0-8]	%
Basophil Auto	1	[0-2]	%
Neutro Abs	1.8	[1.4-6.5]	#
Lymph Abs	1.4	[1.0-4.8]	#
Mono Abs	0.3	[0.1-0.6]	#
Eos Abs	0.1	[0.0-0.7]	#
Basophil Abs	0.0	[0.0-0.2]	#

09/15/2004 08:38:00 AM ..Auto Diff:
ROOM 113

%%END

PRINTED BY: b19310 DATE 9/21/2004

OPREPORT%%
BAPTIST HEALTH
2015
MARTIN, MARLON ""
E0425900082
E000252322

PATIENT VERIFICATION DATA:
MARTIN, MARLON ""- 0425900082

DATE OF SURGERY: 09/15/2004

PREOPERATIVE DIAGNOSIS: Right knee ACL tear.

POSTOPERATIVE DIAGNOSIS: Right knee lateral meniscus tear and ACL tear.

OPERATION:

ANESTHESIA: General.

ASSISTANT:

Estimated blood loss 30 cc. Tourniquet time 90 minutes plus 110 minutes for surgery.

INDICATIONS: Patient is a 33 year old gentleman who injured himself in 2000. Right knee has continued to have pain. MRI scan shows a tear of the ACL.

FINDINGS: Medial meniscus was intact.

There is a complete rupture of the ACL , only scar tissue left in the area where the ACL used to be. There is a tear of the posterior horn of the lateral meniscus and tears along the periphery of the lateral meniscus. The medial femoral condyle and medial tibial condyle, lateral femoral condyle and lateral tibial condyle shows some softening.

There is fraying and softening of patella undersurface.

The PCL was intact.

PROCEDURE: With satisfactory anesthesia the right leg was prepped with Betadine and draped free in the usual fashion. Anterolateral, supermedial and anteromedial portals were used to introduce instruments. The instruments revealed the findings above. A rongeur was used to remove the torn portions of the lateral meniscus, all surfaces then shave, we removed the scar tissue in the condylar notch in preparation for the graft.

A bone bur was used to bur portions of the lateral femoral condyle in the intercondylar notch area to perform a notch plasty.

The Dupuy endoscopic ACL system was used. A 20 cm. long incision was made over the patella, patella tendon and tibial tubercle with proper saw and knife. A 10 mm. wide central patella tendon graft was obtained with a bone plug on either end of about 25 mm. x 10 mm. Drill holes were made in the bone plugs. The graft was then laid

(CONTINUED)

during the time of pr ration of the graft.

The tourniquet was reinflated. With the tibial guide a 10 mm. tibial hole was made in the proximal tibia. Through this hole was introduced a femoral guide and guide pin was placed into the area of the intercondylar notch. The drill was then used to make a 35 mm. tunnel in this area. The guide pin was passed through the anterior lateral femoral complex and through the skin of the anterior thigh.

The graft was then placed onto the eye of the guide pin and pulled through the tibial tunnel joint and into the femoral tunnel. With proper tension in the graft and with a guide pin, a 25 mm. long 9 mm. screw was placed in the tunnels to fix the bony plug and the tunnel. This was tested after this. Range of motion was 0 to 100 degrees of flexion without any impingement. There was no instability with anterior, posterior, medial and lateral structures. The knee was irrigated. The patella tendon was closed with a running #1 Ethibond stitch. Bone chips were packed in the area where the bone plug was removed from the patella. Subcutaneous tissues were closed with 3-0 Monocryl sutures skin closed with stainless steel staples, 25 % 1/4% Marcaine with Epinephrine was injected into the knee. A tourniquet was deflated. Sterile dressing applied. Patient was awakened and returned to the Recovery Room in stable condition.

TAI Q. CHUNG, M.D.

D: 09/15/2004
T: 09/20/2004
df

Sep-15-04 08:53am From-BAPTIST EAST PAIN MANAGEMENT 3342136251 T-631 P.01/04 F-602

Baptist Medical Center East
PHYSICIAN'S ORDERS

Addressograph Plate: 04259000 82

Surgery Sept. 15,04

Marlon Hutto.

USE BALL POINT PEN ONLY AND PRESS FIRMLY!!

ALLERGIES

ANOTHER BRAND OF GENERICALLY EQUIVALENT PRODUCT MAY BE DISPENSED UNLESS CHECKED OR DESIGNATED

PHYSICIAN'S ORDERS AND SIGNATURE

ROUTINE PRE OPERATIVE ORDERS

DR JM Chung

1 Operative permit for Right knee arthroscopic debridement possible meniscectomy with possible tendon graft

2 **LAB:** *check appropriate diagnosis*

A ___ **CBC:**
- ___ Pre op patient [V72 83]
- ___ Long term use of medications
- ___ Fever
- ___ Abdominal pain
- ___ Other

B ___ **TYPE & SCREEN**

C ___ **CHEM 7:**
- ___ Edema
- ___ Hypertensive disease
- ___ Long term use of medications
- ___ Diabetic
- ___ Nephropathology
- ___ Dizziness
- ___ Other

D ___ **PT PTT**
- ___ Known or suspected coagulation abnormality
- ___ Anticoagulant therapy
- ___ Hemorrhage or anemia
- ___ Pulmonary congestion
- ___ Other
- ___ Cirrhosis hepatitis
- ___ CHF
- ___ Cardiac dysrhythmia
- ___ Dysfunctional uterine bleeding
- ___ Menorrhagia

E **DRUG LEVELS:** *circle appropriate drug*
- ___ Patients taking Digoxin Tegretol Theophylline Dilantin Depakote Phenobarb
- ___ Other

F **URINE PREGNANCY**
- ___ On all menstruating females

G **UA:**
- ___ Diabetic
- ___ Renal glycosuria
- ___ Dehydration
- ___ Stress incontinence
- ___ Fever
- ___ Dysuria
- ___ Abdominal & pelvic pain
- ___ Long term use medication

H **ADDITIONAL LAB TESTS:**
- ___
- ___

BH-8000 Revised 2/03

PRINTED BY: b19310 DATE 9/21/2004

D6) 1167

Baptist Medical Center East
PHYSICIAN'S ORDERS

USE BALL POINT PEN ONLY AND PRESS FIRMLY!!

Add espograph Plate: 04259060 82
Martin, Marlon
Surgery: Sept. 15, 04

ALLERGIES

ANOTHER BRAND OR GENERIC EQUIVALENT MAY BE SUBSTITUTED UNLESS "DAW" IS INDICATED

PHYSICIAN'S ORDERS AND SIGNATURE

ROUTINE PRE OPERATIVE ORDERS

DR

3 **EKG:**

- ___ MVP/murmur or other valve disorder
- ___ Chest pain discomfort pressure
- ___ Hypertensive disease
- ___ Pulmonary congestion & hypostasis (CHF)
- ___ Electrolyte/fluid abnormality
- ___ Tachycardia/palpitation
- ___ Ischemic heart disease (hx MI)
- ___ Dizziness
- ___ Other

4 **CHEST XRAY:**

- ___ Existing pulmonary disease (asthma COPD etc.)
  Specify ___
- ___ Existing cardiac disease (hypertension CHF etc.)
- ___ Internal injury
- ___ Fever
- ___ Cough
- ___ Disorders of bone & cartilage (arthritis)
- ___ Other

5 ___ Antibiotic: ___

6 NPO after midnight

7 ___ ☐ TED or ☐ SCD hose prior to surgery

8 **Other Orders** ___

8 Anesthesia Consult ☐ YES ☐ NO

Signature [signature]

BH-8001 Revised 2/03

PRINTED BY: b19310 DATE 9/21/2004

PRISON H[illegible]L SERVICES: AUTHORI[illegible]T[illegible]N LETTER

Patient Name:	Martin, Marlon	**Inmate Number:**	225145MA
Service Authorized:	Office Visits: Op Orthopedics Referral	**Effective Dates:**	09/21/2004
Effective:	Visits authorized for 60 days from effective date.	**Visits Authorized:**	1
Responsible Facility:	Kilby Correctional Facility	**Contact Name:**	Michelle Pope
Authorization Number:	14211720	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

- **Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.**
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

Clinical Summary or Attached Report

***** For security and safety, please do not inform patient of possible follow-up appointments. *****

Signature of Consulting Physician: _____ Date _____ Time

Reviewed and Signed By
Medical Director: _____ Date _____ Time

PRISON HEALTH SERVICES INCORPORATED

SHORT STAY RECORD 23

(To be used in case infirmed 23 hrs or less)

Temp 98.1 Pulse 88 Resp 20 B/P 112/88 Weight _____ Height _____

Admission Date: 9.20.04

HISTORY OF PRESENT ILLNESS:
ACL Repair

PHYSICAL EXAMINATION:

General Appearance Normal

H - E - E - N & T _____

Heart RRR

Lungs Clear

Abdomen Soft non distended

Bones, Joints, Extremities _____

Neurological _____

Skin WNL, contact dermatitis

LABORATORY & X-RAY:
Ø

CONDITION ON DISCHARGE: Stable

DISCHARGE INSTRUCTIONS: use crutches as directed

FINAL DIAGNOSIS: S/P Knee Surgery ACL Repair

Discharge Date: 9/23/04

Signature of Attending Physician

NAME	ADC#	ROOM NO.	HOSP. NO.	ATTENDING PHYSICIAN
Martin, Malon	225145	M04		Dr. William

70048 (5/92)

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 9.20.04

To: ~~Holman~~ DCC

From: SHCU

Inmate Name: Martin, Marlon **ID#:** 225145

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

May remove to rest & shower on M, W, F, (Knee immobilizer) / Toe touch weight bearing c crutches / Bottom Bunk profile / NO standing greater than 10 mins. x 6 wks

Date: 9.20.04 **MD Signature:** _____ **Time:** 2000

60418

PRISON HEALTH SERVICES INCORPORATED

DAILY PATIENT ASSESSMENT SHEET

Date 9-19-04 → 9-20-04

	11-7	7-3	3-11
Time	2300		
Assessed by (initials):	R		

RESPIRATORY

Quality			
Normal	✓		
Shallow			
Deep			
Labored			
Rate - WNL	✓		
Slow			
Rapid			
Sounds - Clear	✓		
Abnormal			
Cough - Productive			
Non-Productive			
Humidified O2 Therapy			
L/Minute			
Incentive Spirometer			
Suctioning-Oral/NI/Trach			

ABDOMEN

Abdomen soft & nondistended	✓		
Abnormal			
Bowel sounds - Active			
Abnormal			
Pain-Tenderness			

PULSE/RATE

Regular	✓		
Irregular			
Strong	✓		
Weak			
Apical			
Radial	✓		

REFERRALS

Patient Teaching	|	|	|

	11-7	7-3	3-11
Time	2300		
Assessed by (initials):	R		

TUBES AND DRAINAGE

Wound healing S inflammation	|		

WOUNDS/ULCERS/DRESSINGS

Dressing Dry & Intact	✓		
Dressing Changed			
Size	-		
Type Acelip	✓		
Location Rt Leg	✓		

TREATMENTS

	|		

I.V. THERAPY

Bottle #/Rate	|		
Site and Rate checked every two hours			

NURSE'S SIGNATURE:			
RN 11-7		LPN 11-7	
7-3		7-3	
3-11		3-11	

PHS-MD-70055

PRISON HEALTH SERVICES INCORPORATED

DAILY PATIENT ASSESSMENT SHEET

Date: 9-19-04

		11-7	7-3	3-11
	Time	0200	845 A	6:30 PM
	Assessed by (initials):	AJ	EJ	AB
RESPIRATORY	Quality			
	Normal	✓	✓	✓
	Shallow			
	Deep			
	Labored			
	Rate - WNL	✓	✓	✓
	Slow			
	Rapid			
	Sounds - Clear	✓	✓	✓
	Abnormal			
	Cough - Productive			
	Non-Productive			
	Humidified O2 Therapy			
	L/Minute			
	Incentive Spirometer			
	Suctioning-Oral/NI/Trach			
ABDOMEN	Abdomen soft & nondistended	✓	✓	✓
	Abnormal			
	Bowel sounds - Active			
	Abnormal			
	Pain-Tenderness			
PULSE/RATE	Regular	✓	✓	✓
	Irregular			
	Strong	✓		✓
	Weak			
	Apical			
	Radial	✓	✓	✓
REFERRALS	Patient Teaching			

		11-7	7-3	3-11
	Time	0200	845 A	6:30 PM
	Assessed by (initials):	AJ	EJ	AB
TUBES AND DRAINAGE				
	Wound healing Ŝ inflammation			
WOUNDS/ULCERS/DRESSINGS	Dressing Dry & Intact			
	Dressing Changed			
	Size			
	Type			
	Location			
	R leg Ace Wrap immobilized	✓		✓
TREATMENTS				
I.V. THERAPY	Bottle #/Rate			
	Site and Rate checked every two hours			

NURSE'S SIGNATURE:

RN	11-7 A. Jackson, RN	LPN 11-7	11-7
	7-3 E. Fellers RN	7-3	7-3
	3-11 A. Boswell RN	3-11	3-11

PHS-MD-70055

PRISON HEALTH SERVICES INCORPORATED

DAILY PATIENT ASSESSMENT SHEET

Martin, M.

Date 9-17-04 → 9-18-04

		11-7	7-3	3-11
Time		2200	0535	7PM
Assessed by (initials):		PL	EJ	AC
RESPIRATORY	Quality			
	Normal	✓	✓	✓
	Shallow			
	Deep			
	Labored			
	Rate - WNL	✓	✓	✓
	Slow			
	Rapid			
	Sounds - Clear	✓	✓	✓
	Abnormal			
	Cough - Productive			
	Non-Productive			
	Humidified O2 Therapy			
	L/Minute			
	Incentive Spirometer			
	Suctioning-Oral/NI/Trach			
ABDOMEN	Abdomen soft & nondistended	✓	✓	✓
	Abnormal			
	Bowel sounds - Active			
	Abnormal			
	Pain-Tenderness			
PULSE/RATE	Regular	✓	✓	✓
	Irregular			
	Strong	✓		✓
	Weak			
	Apical			
	Radial	✓	✓	✓
REFERRALS	Patient Teaching			

		11-7	7-3	3-11
Time		2200	0535	7PM
Assessed by (initials):		PL	EJ	AC
TUBES AND DRAINAGE				
	Wound healing S inflammation			
WOUNDS/ULCERS/DRESSINGS	Dressing Dry & Intact		✓	✓
	Dressing Changed			
	Size			
	Type			
	Location			
	Rt leg immobilizer	✓	✓	✓
TREATMENTS	PRN			
I.V. THERAPY	Bottle #/Rate			
	Site and Rate checked every two hours			

NURSE'S SIGNATURE:	RN 11-7	LPN 11-7	11-7
	7-3 E Fuentes, RN	7-3	7-3
	3-11 R Boswell RN	3-11	3-11

PHS-MD-70055

PHS
PRISON HEALTH SERVICES INCORPORATED

EMERGENCY

ADMISSION DATE 8/17/04 TIME 3:10 AM (PM)
ORIGINATING FACILITY Dothan ☐ SIR ☐ PDL ☐ ESCAPEE ☐
☐ SICK CALL ☐ EMERGENCY ☐ OUTPATIENT

ALLERGIES NKA
CONDITION ON ADMISSION ☑ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

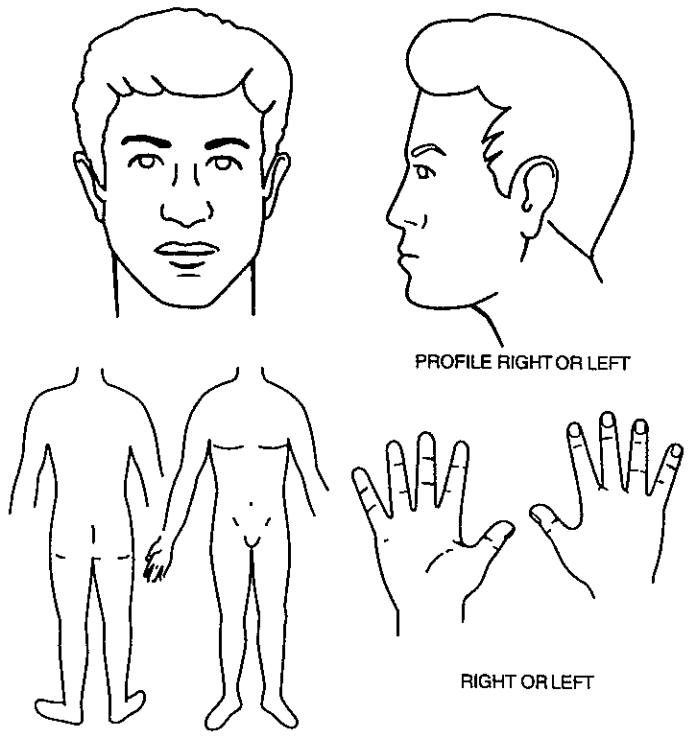
VITAL SIGNS: TEMP 97.8 ORAL / RECTAL RESP. 20 PULSE 66 B/P 120/80 RECHECK IF SYSTOLIC <100> 50 ___/___

NATURE OF INJURY OR ILLNESS

S - Body Chart ☐ FWA

O - AAOX3 Skin W/D. Resp E ease. No Bruising or Inflammation noted. ☐ S/S of Distress or Discomfort

ABRASION /// | CONTUSION # | BURN XX XX | FRACTURE Z Z | LACERATION / ___ SUTURES



PHYSICAL EXAMINATION

A - Body Chart

P - DOC

ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY

DIAGNOSIS

INSTRUCTIONS TO PATIENT

DISCHARGE DATE 8/17/04 TIME 3:15 AM (PM)
RELEASE / TRANSFERRED TO ☑ DOC ☐ AMBULANCE ☐
CONDITION ON DISCHARGE ☑ SATISFACTORY ☐ FAIR ☐ POOR ☐ CRITICAL

NURSE'S SIGNATURE [signature] LPN DATE 8/17/04
PHYSICIAN'S SIGNATURE DATE
CONSULTATION

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
Morton, Marlon	225148	12/17/76	B/M	DCC

PHS-MD-70007 (White – Record Copy, Yellow – Pharmacy Copy)

PHS PRISON HEALTH SERVICES INCORPORATED

EMERGENCY

ADMISSION DATE 8/17/04	TIME 3:10 AM (PM)	ORIGINATING FACILITY Draper ☐ SIR ☐ PDL ☐ ESCAPEE ☐	☐ SICK CALL ☐ EMERGENCY ☐ OUTPATIENT
ALLERGIES NKA		CONDITION ON ADMISSION ☑ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA	

VITAL SIGNS: TEMP 97.8 ORAL RECTAL RESP. 20 PULSE 66 B/P 120/80 RECHECK IF SYSTOLIC <100> 50 /

NATURE OF INJURY OR ILLNESS

S - Body Chart p̄ FWA

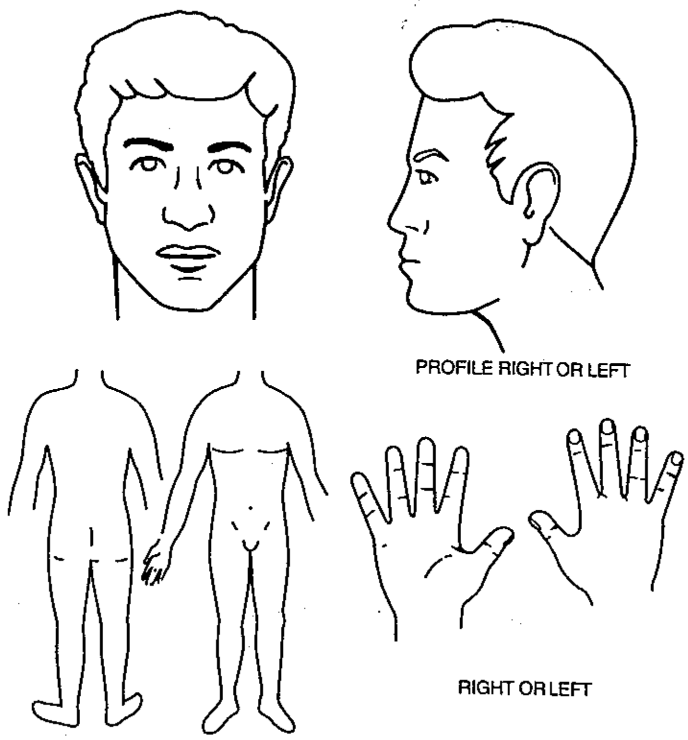
O - AAOx3 Skin w/d, Resp c̄ ease. No Bruises or inflammation noted. Ø s/s of distress or discomfort

PHYSICAL EXAMINATION

A - Body Chart

P - DOC

ABRASION ///	CONTUSION #	BURN xx xx	FRACTURE Z Z	LACERATION / ____ SUTURES



ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY

DIAGNOSIS

INSTRUCTIONS TO PATIENT

DISCHARGE DATE 8/17/04 TIME 3:15 AM (PM)	RELEASE / TRANSFERRED TO	☑ DOC ☐ AMBULANCE ☐	CONDITION ON DISCHARGE ☑ SATISFACTORY ☐ FAIR ☐ POOR ☐ CRITICAL
NURSE'S SIGNATURE [signature] LPN DATE 8/17/04	PHYSICIAN'S SIGNATURE	DATE	CONSULTATION

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
Martin Marlon	225148	12/17/70	B/M	DCC

PHS-MD-70007 (White – Record Copy, Yellow – Pharmacy Copy)

PRISON HEALTH SERVICES INCORPORATED

INFIRMARY ADMISSION

INMATE NAME: Marlon Marlon DOC# 225145

ADMISSION DATE: 17Sep04

ADMITTING DIAGNOSIS: (R) ACL Repair ?

ADMITTING PHYSICIAN:

ESTIMATED LENGTH OF STAY: unknown

E0425900082 MARTIN,MARLON
DOB: 12/17/70 Age:33Y MR #:252322
Admit Date/Time: 09/15/04 0737A
2015 CHUNG,TAI Q

Baptist Health

PHYSICIAN'S ORDERS

Height:____

Drug Sensitivities and Allergies ❑ NKDA ❑ Yes, list: ______

DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE
'u' or 'U'	Unit	MS, MSO4 MgSO4	Spell out words	TIW	Spell out words	Per os or OS	Spell out by mouth/oral
IU	International Unit	.Xmg	0.Xmg	µg	microgram	BT	Spell out Bedtime
QD/QOD	Spell out words	X.0 mg	'X' mg	AD, AS, AU	Spell out words	QN or qn	Spell Out Nightly or at Bedtime

Date	Time	
9/17/04		(1) Discharge
	1000	(2) Give the following orders to his attendants.
		To return to this facility
	Faxed	(1) Toe touch weight bearing on (R) leg
		(2) May be out of knee immobilizer to move knee.
		Keep immobilizer on when up.
		(3) Change dressing prn
		(4) Vicodin ii po q4h prn pain
		(6) Ice to the knee prn
		(7) See me in 2 wks c X-r (R) knee
		[signature] [signature]

Physician Signature:

PH 350

DO NOT WRITE BELOW THIS LINE

Form #PH 35001 Revised 3/24/0

... with the Authorization Letter to the service provider at the time of the Appointment. Print

PHS

DEMOGRAPHICS

Site Name & Number: Kilby #840

Site Phone #: 334-215-6706

Site Fax #: 334-215-9126

Will there be a charge? ☐ Yes ☐ No

Sex ☐ Male ☐ Female

Patient Name: (Last, First) Martin, Marlon

Alias: (Last, First)

Inmate #: 225145

SS Number: ___-__-____

Date: (mm/dd/yy) 09/17/04

Date of Birth: (mm/dd/yy) 12/17/70

PHS Custody Date: (mm/dd/yy) __/__/__

Potential Release Date: (mm/dd/yy) __/__/__

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid): ____

CLINICAL DATA

Requesting Provider: ☐ Physician ☐ NP, PA ☐ Dental

Dr Chung

Facility Medical Director Signature and Date: [signature]

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) 10/01/04

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy ☐ Other: ____

Number of Visits/Treatments: ____

Specialist referred to:

Type of Consultation, Treatment, Procedure or Surgery:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/sypmtoms with Date of Onset:

S/P ACL repair (R) leg

Results of a complaint directed physical examination:

Previous treatment and response (including medications):

*****For security and safety, please do not inform patient of possible follow-up appointments*****

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

☐ Offsite Service Recommended and Authorized

Date resubmitted: __/__/__

Regional Medical Director Signature, printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY. __/__/__ (mm/dd/yy)

Cert Type:

Med Class:

UR Auth #:

UM Referral review form 2-05-2004

Patient Information

Baptist HEALTH

DISCHARGE INSTRUCTIONS

Date: 9-17-04

Discharged to: ☒ Home ☐ Home with Home Health ☐ Assisted Living

Home with equipment: ☐ Wheelchair ☐ Cane ☐ Walker ☐ Crutches ☐ Oxygen ☐ Other_____

DISCHARGE INSTRUCTIONS:

- Diet: ☒ Regular ☐ Special: _____
- Activity per physician's instructions. Call physician if you have questions.
- Treatment to continue at home: See orders. Ice pk. to knee prn. Change dsg prn Immobilizer on when up. Toe touch weight bearing on Rt. leg
- Physician pre-printed instructions reviewed and provided.
- Other pre-printed instructions provided: (list)_____

FOLLOW-UP APPOINTMENT(S):

Dr. Chung 2 wks. + X-ray Rt. Knee Day_____ Date_____ Time_____ ☐ AM ☐ PM

Dr. _____ Day_____ Date_____ Time_____ ☐ AM ☐ PM

VACCINATIONS

Patient up to date on:

☐ Flu Vaccine (October - March) **If No:** ☐ administered ☐ contraindicated

☐ Pneumonia Vaccine (within the last 5 years) **If No:** ☐ administered

TARGET EDUCATION

☐ Smoking cessation ☐ Low-molecular weight heparin

☐ Coumadin ☐ Insulin ☐ Pain medication

NEW MEDICATIONS

☐ **Education for new medications provided** ☐ **Prescriptions given (if applicable)**

	Drug Name	Dose	Frequency	Prescription Given	Education Provided
1.	Vicodin	2	Q4 hrs. prn		
2.					
3.					
4.					
5.					
6.					

CONTINUE THESE MEDICATIONS:

	Drug Name	Dose	Frequency		Drug Name	Dose	Frequency
1.				6.			
2.				7.			
3.				8.			
4.				9.			
5.				10.			

Time of Discharge:_____ ☐ a.m. ☒ p.m. Method of Discharge: ☒ Wheelchair ☐ Stretcher ☐ Carried (Infant) ☐ Other_____

I understand the above instruction(s). I have received my personal belongings, home medication(s), follow-up instructions and prescriptions (if applicable.)

Nurse: LAW Date 9-17-04

Patient/Patient Rep. Thomas Tolbert Date_____

DI 1440

White- Medical Records Yellow- Patient Form DI 14405 Revised 6/02/04 **Page 1 of 2**

INFIRMARY ASSESSMENT

DATE: 17Sep04 PATIENT: Marton, Marlon

KEY/DIRECTIONS:

✓ Assessment done; No changes found within established criteria.

* Assessment done; changes found outside established criteria, details in progress notes.

\# Notation in progress notes (indicate in signature/title block)

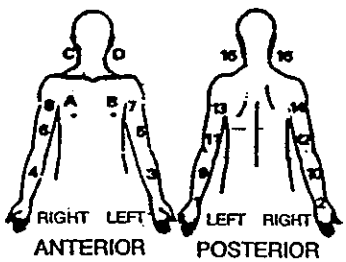
PC Assessment done; changes found outside established criteria; secondary to pre-existing condition.

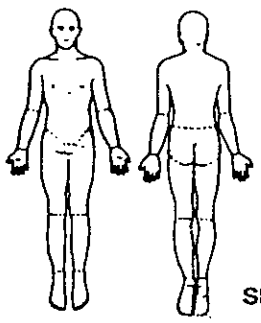
PHYSICAL ASSESSMENT:

	7-3			3-11			11-7		
	TIME	SYMBOL	INITIAL	TIME	SYMBOL	INITIAL	TIME	SYMBOL	INITIAL
NEUROLOGICAL (A/A/O, MEMORY INTACT, PEARL, ACTIVE ROM TO ALL EXTREMITIES, SPEECH CLEAR)									
NEUROVASCULAR (SKIN WARM, DRY, PINK + PERIPHERAL PULSES PALPABLE, NO EDEMA, + SENSATION)									
RESPIRATORY (RATE 10-20 B/MIN AT REST, QUIET, REGULAR, CLEAR SPUTUM, PINK NAILBEDS, NORMAL BREATH SOUNDS)									
CARDIOVASCULAR (S_1 S_2 AUDIBLE, + APICAL PULSE, HR REGULAR, VSS; SKIN WARM/DRY)									
GASTROINTESTINAL (ABDOMEN SOFT, + BOWEL SOUNDS IN ALL FOUR QUADRANTS)									
GENTIOURINARY (URINE CLEAR, YELLOW TO AMBER, NO PAIN, VOID) (NO VAG/PENILE DISCHARGE)									
INTEGUMENTATION (NO RASHES, NO BREAKDOWN, NO RED AREAS)									
MUSCULOSKELETAL (NO JOINT SWELLING/TENDERNESS /WEAKNESS)									
PSYCH/SOCIAL (APPEARANCE, BEHAVIOR, VERBALIZATION APPROPRIATE TO SITUATION)									
PAIN (IF RELIEVED BY MEDS, INDICATE IN PROGRESS NOTES									

IV THERAPY: TYPE

HL-HEPLOCK
IV-INTRAVENOUS
A-B-CVP
C-D-INT. JUGULAR
#15-16 - EXT. JUGULAR





	7-3	3-11	11-7
SITE #1			
TYPE			
CONDITION			
SITE #2			
TYPE			
CONDITION			
TIME DRESSING CHANGED			
TIME TUBING CHANGED			
RESTART: CATH GAUGE			
TIME			
LOCATION #			
INCISIONAL/WOUND CARE: LOCATION/IDENTIFY SITE			
SUTURES/CLIPS			
DRAINS, TYPE			
DRAINAGE TYPE			
TIME DRSG. CHANGED			
SIGNATURES/TITLES:			

PATIENT CARE NOTES

Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: Kilby #840

Site Phone #: 334-215-6706

Site Fax #: 334-215-9126

Will there be a charge? ☑ Yes ☐ No

Sex: ☐ Male ☐ Female

Patient Name: (Last, First) Martin, Marla

Alias: (Last, First)

Inmate #: 225145

SS Number

Date: (mm/dd/yy) 09/20/04

Date of Birth: (mm/dd/yy) 12/12/70

PHS Custody Date: (mm/dd/yy)

Potential Release Date: (mm/dd/yy)

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Dr Chung

Facility Medical Director Signature and Date:

Mike Robbins

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy)

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: ____ ☐ Other:

Specialist referred to:

Type of Consultation, Treatment, Procedure or Surgery:

Ortho F/U in 2wks
per Dr Robbins 10/04/04

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

S/P ACL repair
(R) 2004

Results of a complaint directed physical examination:

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

☐ Offsite Service Recommended and Authorized

Date resubmitted:

Regional Medical Director Signature, printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Mod Class:

UR Auth #:

(mm/dd/yy)

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 09/20/04

To: ICS office

From: PHS - Glenda Tyree lpn

Inmate Name: Martin, Marlon **ID#:** 225145

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Discharge to DOC - Return to prior facility

Date: 09/20/04 **MD Signature:** V.O. Dr Robbins / G Tyree **Time:** _____

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 09/20/04

To: ICS Office

From: PHS - Glenda Tyree LP

Inmate Name: Martin, Marlon **ID#:** 225145

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Use Crutches x2 per Dr Robbins

Date: 09/20/04 **MD Signature:** V.O. Dr Robbins / G Tyree L **Time:** _____

60418

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 09/20/04

To: ICS Office

From: PHS - Glenda Tyree lpn

Inmate Name: Martin, Marion **ID#:** 225145

The following action is recommended for medical reasons:

1. House in
2. Medical Isolation
3. Work restrictions
4. May have extra
5. Other until

Comments:

Bottom Bunk Profile due to (R) leg per Dr Robbins, Limited Walking and Standing x 6 wks starting 09/20 - 11/01/04

Date: 09/20/04 **MD Signature:** Dr Robbins/G. Tyree lpn **Time:** 0735/A

60418

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 8/17/04

To: Draper

From: HCU

Inmate Name: Martin, Marlon **ID#:** 225145

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____
5. Other _____ until _____

Comments:

No prolonged standing >20mins x 180 days.

Date: _____ **MD Signature:** D M Blunt **Time:** _____

60418

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 7/23/04

To: Draper

From: HCU

Inmate Name: Martin Mortimer **ID#:** 225145

The following action is recommended for medical reasons:

1. House in ~~_____~~
2. Medical Isolation ~~_____~~
3. Work restrictions No prolonged standing greater than 30 mins
4. May have extra ~~_____~~ ~~until~~ until evaluated
5. Other by orthopedist

Comments:

TORN ACL (R) Knee

Date: 7/23/04 **MD Signature:** [signature] **Time:** 925

60418

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 5/19/04

To: Drayer

From: Shell

Inmate Name: Martin, Marlon **ID#:** 225145

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

No prolonged standing >20min X 60days

Date: 5/19/04 **MD Signature:** D. McArthur, P.A./D. Hughston MD **Time:** _____

60418

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 5/10/04

To: Draper

From: STCU

Inmate Name: Martin, Marlon **ID#:** 225145

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions No prolonged standing > 20min X 60 days
4. May have extra _____ until _____
5. Other _____

Comments:

Your MRI is Pending

Date: 5/10/04 **MD Signature:** D. McArthur, P.A/NP **Time:** _____

60418

PHS
PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, Marlon Martin 225145
(Print Name) (Doc#)

acknowledge receipt of the following medical equipment or appliance:

( ) Splint
( ) Eyeglasses
( ) Dentures
( ) Prothesis describe Knee brace
( ) Wheelchair
( ) Cane
( ) Crutches
(X) Other describe

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

(Inmate) 225145 2-22-05
(Date)

J. Naughton LPN
(Witness) 2/22/05
(Date)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
Martin, Marlon	225145		B/M	Draper

PHS-MD-70005

(White – Medical File, Yellow – Security Property Officer)

Disciplinary Segregation Medical Documentation

Initial Assessment

Vital Signs: BP 130/86 P 74/98 R 20

Signs of Trauma ○ No ○ Yes	Describe:
Medical/Mental Health Complaints ○ No ○ Yes	Describe:
Existing Medical/Mental Health Conditions ○ No ○ Yes	Describe:
Signature	Date / Time

Date/Time	1	2	3	4	5	6	7	8	9	10	11	12	13
Crying													
Signs of Trauma													
Oriented x's 3	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Withdrawn						✓	✓	✓	✓	✓	✓	✓	✓
Hostile/Angry													
Quiet	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Manic Behavior						✓	✓	✓	✓	✓	✓	✓	✓
Denies Complaint	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nurse's Signature													

Comments (By Date)

Date Name M Porter MAeller ID#/DOB Race Location

Disciplinary Segregation Medical Documentation

EMERGENCY/ S/Call **TREATMENT RECORD**
(OTHER)

DATE 8/15/03 TIME 11:40 AM/PM | FACILITY Draper. ☐ SIR ☐ PDL ☐ ESCAPEE ☐ | ☐ EMERGENCY ☑ OTHER

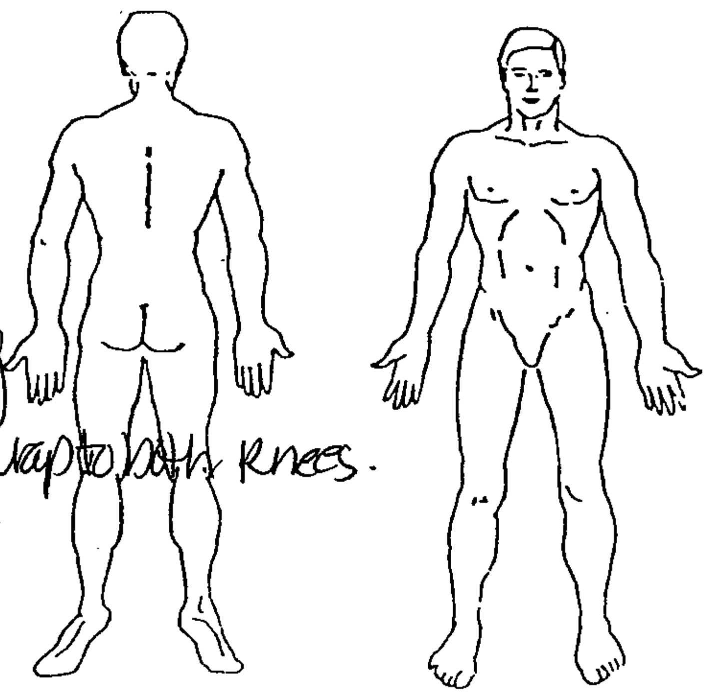
ALLERGIES NKA. | CONDITION ON ADMISSION ☑ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

VITAL SIGNS: TEMP 97.8 ORAL RECTAL RESP. 20 PULSE 76 B/P 110/78 RECHECK IF SYSTOLIC <100> 50

NATURE OF INJURY OR ILLNESS

S. Having problem c knees for duty. They just give out. States they grind and feel there not strong enough

ABRASION/// CONTUSION # BURN xx FRACTURE z LACERATION/ SUTURES



PHYSICAL EXAMINATION

O. Slowly Amb. c limp dragging legs ∅ edema ∅ redness noted. ∅ S/S of infection Ace wrap to both knees. Good ROM noted 90 pain on Abduction. pedal & pop pulse ⊕ and strong. ∅ open areas noted.
A. Alteration in comfort.

ORDERS, MEDICATION, etc.

P. 1) Pt ace wrap reapplied
2) KOP meds PRN
3) Warm compresses per self
4) sign up for sick call
5) MD for review.

DIAGNOSIS

INSTRUCTIONS TO PATIENT

RELEASE/TRANSFER DATE 8/15/03 TIME AM PM | RELEASE/TRANSFERRED TO Draper. ☑ DOC ☐ AMBULANCE ☐ | CONDITION ON DISCHARGE ☑ SATISFACTORY ☐ POOR ☐ FAIR ☐ CRITICAL

NURSE'S SIGNATURE [signature] | DATE 8/15/03 | PHYSICIAN'S SIGNATURE B Nelson CRNP | DATE 8/18/03 | CONSULTATION

PATIENT'S NAME (LAST, FIRST, MIDDLE) Martin, Marlon | AGE 32 | DATE OF BIRTH 12/17/70 | R/S B/M | AIS # 225145.

NC 041 ORIGINAL - MEDICAL RECORD, YELLOW - TRANSFER AGENT

ALABAMA DEPARTMENT OF CORRECTIONS

EMERGENCY/ SHCU (OTHER) TREATMENT RECORD

DATE 7-8-03	TIME 315 AM (PM)	FACILITY Draper ☐ SIR ☐ PDL ☐ ESCAPEE ☐	☐ EMERGENCY ☒ OTHER

ALLERGIES NKDA

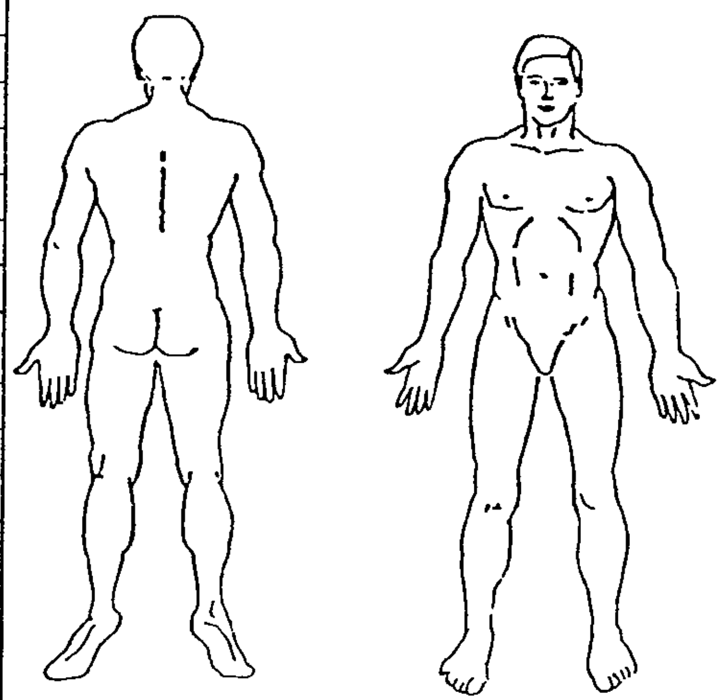
CONDITION ON ADMISSION ☒ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

VITAL SIGNS: TEMP 97.4 (ORAL) RECTAL RESP. 20 PULSE 80 B/P 110/84 RECHECK IF SYSTOLIC <100> 50

NATURE OF INJURY OR ILLNESS

(S) "I just passed out"

ABRASION/// CONTUSION # BURN xx FRACTURE z LACERATION/ SUTURES



PHYSICAL EXAMINATION

(O) Brought to ER via stretcher, A+Ox3, Skin W/D to touch, Resp reg & ease, grip good, PERRL. ∅ SOB, ∅ CP, ∅ slurred speech, ∅ NADN

M. Barnett

States - light headed.

(A) Alteration in comfort

ORDERS, MEDICATION, etc.

(P) MD/CRNP to Review
① Increase fluids.

DIAGNOSIS

INSTRUCTIONS TO PATIENT

Increase fluids & any further problems sign up for S/C

RELEASE/TRANSFER DATE	TIME	RELEASE/TRANSFERRED TO	CONDITION ON DISCHARGE
7/8/03	330 AM (PM)	☐ DOC ☐ AMBULANCE ☐	☐ SATISFACTORY ☐ FAIR ☐ POOR ☐ CRITICAL

NURSE'S SIGNATURE	DATE	PHYSICIAN'S SIGNATURE	DATE	CONSULTATION
M Barnett	7/8/03	[signature]	7/8/03	

PATIENT'S NAME (LAST, FIRST, MIDDLE)	AGE	DATE OF BIRTH	R/S	AIS #
[illegible], Marlene	32	12/17/70	BM	225145

NC 041

ORIGINAL - MEDICAL RECORD, YELLOW - TRANSFER AGENT

EMERGENCY/ SHCU/DCC (OTHER) TREATMENT RECORD

DATE 9-5-03 TIME 5 AM PM | FACILITY Draper ☐ SIR ☐ PDL ☐ ESCAPEE ☐ | ☒ EMERGENCY ☐ OTHER

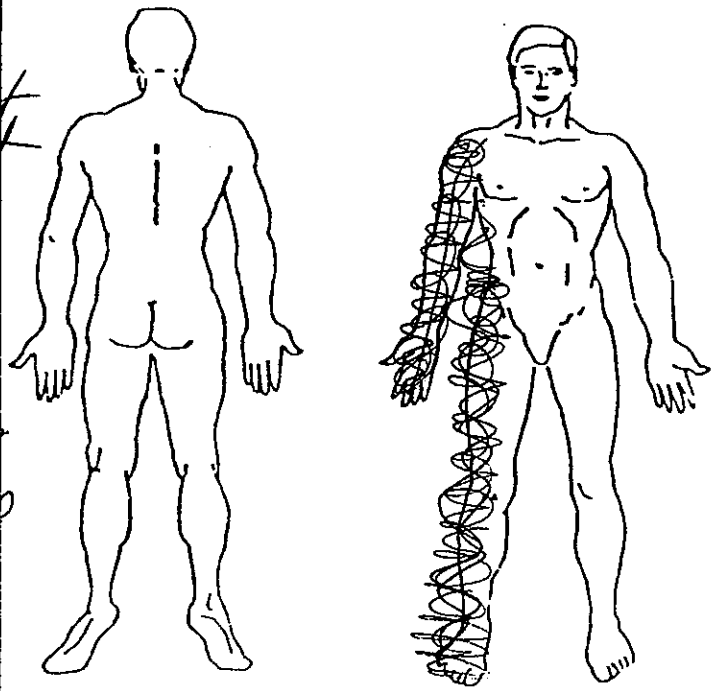
ALLERGIES NKA | CONDITION ON ADMISSION ☐ GOOD ☒ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

VITAL SIGNS: TEMP 97.2 ORAL RECTAL RESP. 16 PULSE 86 B/P 140/80 RECHECK IF SYSTOLIC <100> 50

O2SAT 95-96 on RA

NATURE OF INJURY OR ILLNESS

ABRASION/// | CONTUSION # | BURN xx xx | FRACTURE Z Z | LACERATION/ SUTURES



S- very numb from ~~left~~ Right arm down whole Right side into back. been ongoing for about a month. before cl get up and walk cl have to massage my leg to get the circulation going in it.

PHYSICAL EXAMINATION

O- VSS, continuously working fingers from numbness. walks well & assistance when asked. inmates states it is "an annoying numbness that won't go away." finger tips have good cap refill, nail beds pink, fingers warm. left side has Ø SX/Ø problems. A&O x3. Ø memory loss noted. Ø difficulties speaking or swallowing.

A- EKG done alteration in comfort R/T numbness

P- notify MD of EKG and symptoms.

E- ✓ pill call and sign up for sick call Sunday if Ø better

ORDERS, MEDICATION, etc.

DIAGNOSIS

INSTRUCTIONS TO PATIENT

RELEASE/TRANSFER DATE 9/5/03 TIME 5:00 AM PM | RELEASE/TRANSFERRED TO ☒ DOC ☐ AMBULANCE ☐ | CONDITION ON DISCHARGE ☐ SATISFACTORY ☐ POOR ☒ FAIR ☐ CRITICAL

NURSE'S SIGNATURE K Reams Law | DATE 9-5-03 | PHYSICIAN'S SIGNATURE | DATE | CONSULTATION

PATIENT'S NAME (LAST, FIRST, MIDDLE)	AGE	DATE OF BIRTH	R/S	AIS #
Martin, Marlon	32	12/17/70	BM	225145

NC 041 ORIGINAL - MEDICAL RECORD, YELLOW - TRANSFER AGENT

09/05/2003 05:25:28 PM martin,marion
32 years Male Race: b

BP 140/80

Dept: nursing
Room:
Oper: aah

Rate 78
PR 160
QRSD 82
QT 351
QTc 400

--AXIS--
P 80
QRS 67
T 47

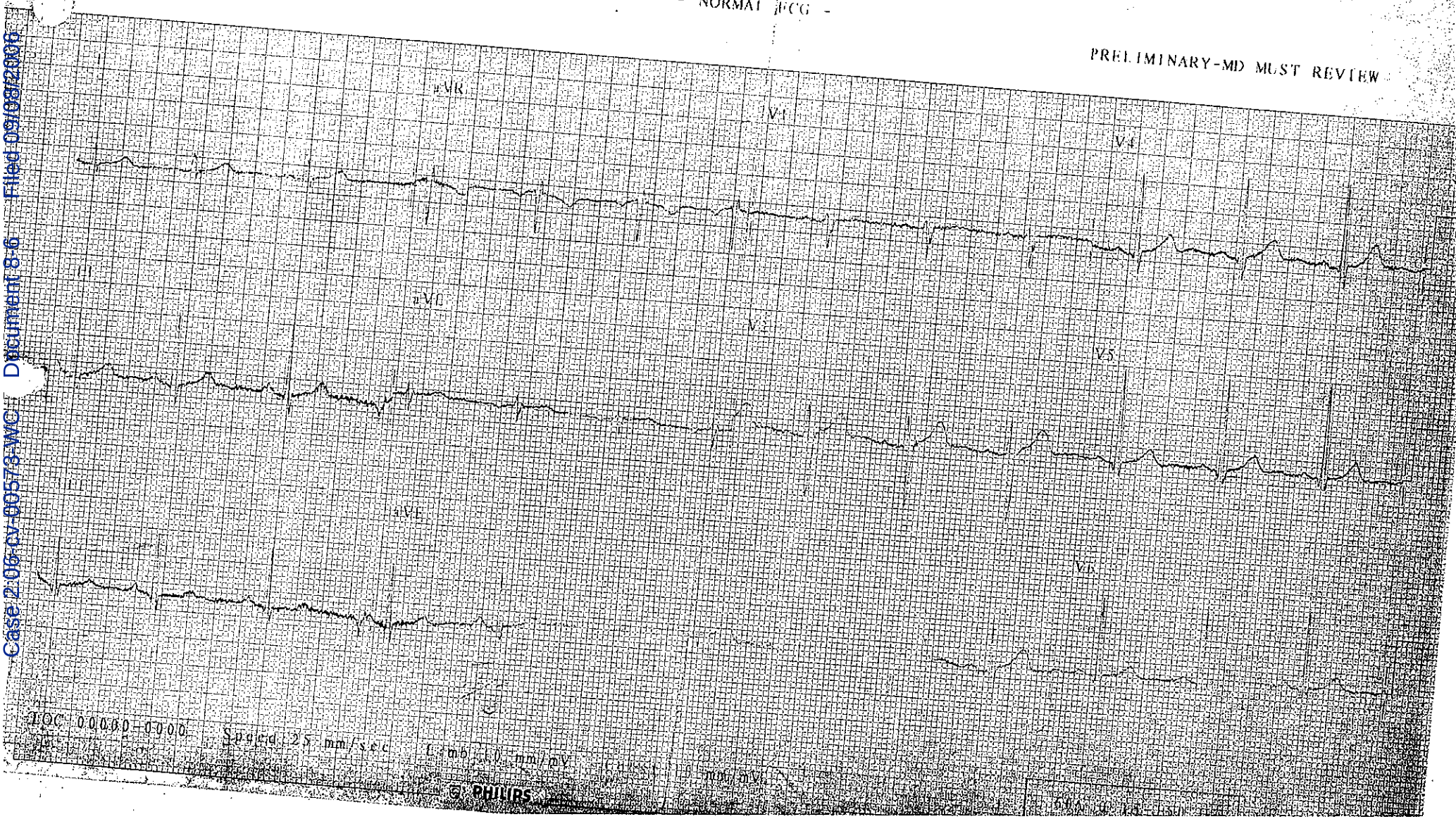
Normal sinus rhythm, rate 78.

Normal P axis, PR, rate & rhythm

Requested by:
sonnier

- NORMAL ECG -

PRELIMINARY-MD MUST REVIEW



TOC 00000-0000 Speed 25 mm/sec 1 mV = 10 mm/mV Gain 1 10 mm/mV

DEPARTMENT OF CORRECTIONS

EMERGENCY/ SICK (OTHER) TREATMENT RECORD

2:34

DATE 6/8/03 TIME (AM) PM FACILITY Dcc ☐ SIR ☐ PDL ☐ ESCAPEE ☐ ☐ EMERGENCY ☑ OTHER

ALLERGIES NKA CONDITION ON ADMISSION ☑ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

VITAL SIGNS: TEMP 100.0 ORAL RECTAL RESP. 20 PULSE 100 B/P 112 176 RECHECK IF SYSTOLIC <100> 50

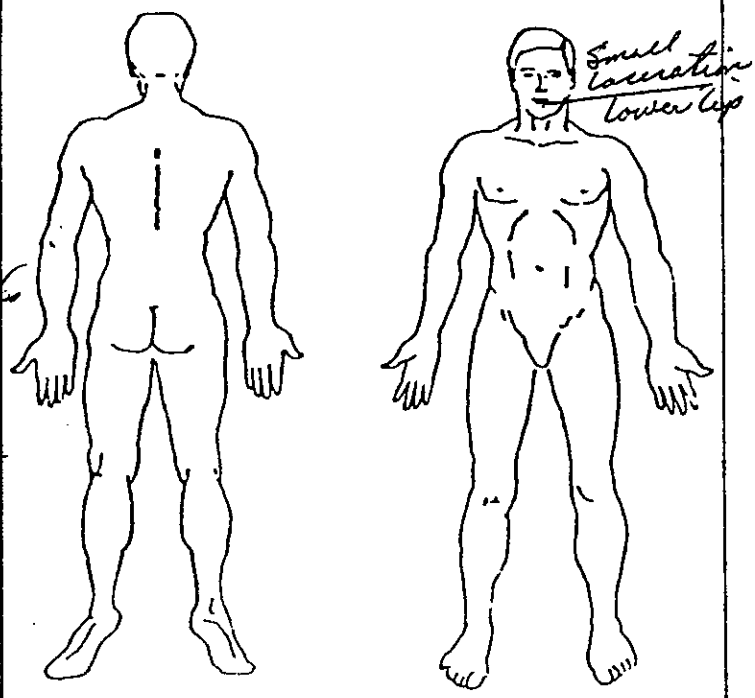
NATURE OF INJURY OR ILLNESS

(S) Body Chart per DOC

"my bottom lip is cut"

Escorted by Officers Boyd and Wood

ABRASION/// CONTUSION # BURN xx xx FRACTURE Z Z LACERATION/ SUTURES



PHYSICAL EXAMINATION

(O) Very small laceration to lower lip - ☐ bleeding @ this time - ☐ bruising or swelling - WDWN

(A) Body Chart

ORDERS, MEDICATION, etc.

(P) Release to DOC

Laceration to lip cleaned ē H_2O_2 and TAO applied - left open to air

DIAGNOSIS

INSTRUCTIONS TO PATIENT

RELEASE/TRANSFER DATE 6/8/03 TIME (AM) PM (43) RELEASE/TRANSFERRED TO ☑ DOC ☐ AMBULANCE ☐

CONDITION ON DISCHARGE ☑ SATISFACTORY ☐ POOR ☐ FAIR ☐ CRITICAL

NURSE'S SIGNATURE	DATE	PHYSICIAN'S SIGNATURE	DATE	CONSULTATION
B Buckhalter	6/8/03	B Helms clms	6-9-03	

PATIENT'S NAME (LAST, FIRST, MIDDLE)	AGE	DATE OF BIRTH	R/S	AIS #
Morley, Anthony	18	7/31/84	W/M	215522

NC 041 ORIGINAL - MEDICAL RECORD, YELLOW - TRANSFER AGENT

0

ALABAMA DEPARTMENT OF CORRECTIONS

RECEIVING SCREENING FORM

ate's Name: Marlon Martin 225145 Date: 12/23/2005 Time: 11:40 am

e: 12-17-70 Officer: CS Institution: DCC

Booking Officer's Visual Opinion	Yes	No
Is the inmate conscious?	✓	
Does the inmate have any obvious pain or bleeding/other symptoms suggesting the need for emergency services?		✓
Are there any visible signs of trauma or illness requiring immediate emergency treatment or doctor's care?		✓
Any obvious fever, swollen lymph nodes, jaundice, or other evidence of infection which might spread through the institution?		✓
Is the skin in poor condition or show signs of vermin or rashes?		✓
Does the inmate appear to be under the influence of alcohol or drugs?		✓
Are there any visible signs of alcohol or drug withdrawl? (extreme perspiration, shakes, nausea, pinpoint pupils, etc.)		✓
Is the inmate making any verbal threats to staff or other inmates?		✓
Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?		✓
Does the inmate have any obvious physical handicaps?		✓

If the answer is YES to any questions from 2-10 above, specify WHY in section below.

Are you presently taking medication for diabetes, heart disease, seizure, arthritis, asthma, ulcers, high blood pressure or psychiatric disorder?		✓
Are you on any special diet prescribed by a physician? (if YES, what type?)		✓
Do you have a history of venereal disease or abnormal discharge?		✓
Have you recently been hospitalized or recently seen a medical or psychiatric doctor for any illness?		✓
Have you ever attempted suicide?		✓

If YES, When? _____ How? _____

DEPARTMENT OF CORRECTIONS

PATIENT CONSENT TO TREATMENT FORM

Marlon Martin — Name of Patient
31 — Age
12-11-02 — Admission date/time

Name and Address of Spouse or Parent

1. I hereby authorize the Department of Corrections, its contracted employees, agents, physicians, dentists, psychiatrists and/or such assistants as may be selected by him/her to treat the condition(s) which appear indicated by the diagnostic studies already performed.

2. Should surgical or diagnostic procedure(s) become necessary, I will be informed of them with regard to alteration modes of treatment, the risks involved, and the nature of the procedure(s) to be done.

3. This in no way constitutes a warranty or guarantee that my present condition will be cured; the Department of Correction, its contracted staff and employees, will provide with the best possible care available, but no assurance of cure is to be assumed.

4. I sign this willingly and voluntarily in full understanding of the above, and in so doing I release the Department of Correction, its directors and officers, its contracted staff employees, agents, and physicians from any and all liability which may arise from this action, whether or not foreseen at present.

R.T
Witness

Witness

Marlon Martin
Patient Signature

12-11-02
Date

F-83

ACCESS TO HEALTH CARE SERVICES @ KILBY NAPHCARE

All inmates have access to healthcare 24 hrs. a day, 7 days a week. Treatment for routine health services complaints is processed through nurse sick call. You must complete a sick call screening form for requested health care evaluation.

Various doctor's clinics are held in the health unit Monday through Friday. If you are scheduled to be seen in a clinic you will be advised by facility daily newsletters routinely post notices of who is to report when and where for health care services. If you complete a sick-call form, please report to sick call the next business day, no later then 5:30am. Routine sick call will not be posted in the newsletter, but D.O.C. has a log of who has signed up for sick call.

If you request health services and do not show for evaluation you must sign a refusal of treatment form. If a health services appointment/clinic or treatment has been set for you and you do not show you will also have to sign a refusal of treatment for. This is to let us know you have decided you are okay and no longer need to see us.

Nurses are in house twenty-four hours a day seven days a week for rontine health services and programs. Nurses are also available for emergency care. Doctor's are on call twenty-four hours a day seven days's a week.

In-house medical staff reviews medical services requested over the weekend and on holidays. If your request is noted to be of a nature that will not wait until the next regularly scheduled evaluation (triage) time, you will be called to the health unit for further follow-up during this time period other wise your request will be held until the next regularly scheduled evaluation process.

Medical emergencies such as those involving intense pain, potential life threatening situations or when delaying treatment might cause permanent damage are dealt with at any time. Advise the nearest correctional officer of an emergency so prompt access to health services is provided.

Medications ordered for you by health services are to be picked up at the scheduled pill call/s established as the Doctor has ordered for you. If you fail to pick-up medications as expected you will be called for counseling. If you continue to fail to pick-up your medications you will be required to sign a refusal of treatment form.

Remember that health services are a joint effort between the patient and the health car provider. We expect you to help us help you.

Fee for services. You truly understand that no one would be denied access to health services because they are unable to pay the $3.00 co-pay fee. You will be seen and services will be provided that are appropriate and deemed necessary. Health services staff

does not collect c ay fees for health services nor do mon collected go to the medical provider. A nurse visit or doctor visit charge of $3.00 is the co-pay fee. If you do not have money in your PMOD account and you are accessed a charge you will have a negative balance in your until this is cleared. A negative balance will follow you from institution to institution upon transfer. When you seek health services you will be asked to sign the co-pay signature sheet. If it is deemed that you indeed do not owe for services your account will not be charged and if a false charge is made you will be refunded. Again we do have money and are eligible to be charged the co-pay fee this will occur. If the health unit initiates the request for you to be seen there is no charge.

Educational in-services are routinely scheduled. Please attend and participate. Notice of in-services topics, dates and times will be published and posted in advance.

Complaints against health care are attempted to be resolved as soon as possible and as reasonably as possible. You may obtain a complaint form from the same place you obtain sick call request slips and you may return these where you return your sick call request slips. If your complaint is not resolved when health services person speaks with you, you may file a grievance. This form will be given to you by the health person that has attempted to resolve the complaint. A complaint form must be initiated before a grievance form can be completed.

Let your family and loved one's know health services will not disclose your medical care through conversations with them. If we are contacted you should know that we will review your health records but will have to let them know what you feel they should know about you. Understand, we will assure your family and loved one's you have health services available. We will also tell them that they must go through you or the Department of Corrections fro release if information and that you must go through the appropriate procedures and access health services and also follow medical service recommendations. Be compliant with the health services ordered for you by your health providers.

If you have had health services outside the prison setting and we do not have these records you will need to sign release of records forms so we can obtain copies for placement in your institutional health record.

A physical is begun on you upon your arrival into the prison system. You will be notified yearly thereafter when you next physical is scheduled.

Mental health services dental services; medical services, chronic care clinics and many other health services are available. We wish you a healthy stay. If you need medical services we want you to understand how these services are obtained.

Certain over the counter medications are available to you through canteen purchase. Medical service is not involved in canteen operations.

We follow doctors when dispensing medication-dose time. If over the counter medication is given by health services it is through the order of a doctor.

Population pill call at this institution are scheduled as listed below. If you have medication ordered report to the pill call your medication is to be dispensed at.
3:00AM
9:00AM
3:00PM
6:00PM

segregation lock-up pill call times are as listed below. Your medication will be issued to you on medication rounds.

3:00 AM
8:00 AM
2:30PM

If you have a question request an answer.

Marlon Martin 12-11-02
INMATE SIGNATURE/ DATE

WITNESS SIGNATURE/DATE

RECEIVING SCREENING FORM

INMATE'S NAME: Martin, Marlon DATE: 12/10/02 TIME: 9:00 AM

DOB: 12-17-70 OFFICER: D. Dunn INSTITUTION: KILBY

RECEIVING OFFICER'S VISUAL OPINION

	YES	NO
Is the inmate conscious?	✓	
Does the inmate have any obvious pain or bleeding or other symptoms suggesting the need for doctor's care?		✓
Are there any visible signs of trauma or illness requiring immediate emergency or doctor's care?		✓
Any obvious fever, jaundice, or other evidence of infection which might spread through the institution?		✓
Is the skin in poor condition or show signs of vermin or rashes?		✓
Does the inmate appear to be under the influence of alcohol, or drugs?		✓
Are there any signs of alcohol or drug withdrawal? (Extreme perspiration, shakes, nausea, pinpoint pupils, etc.)		✓
Is the inmate making any verbal threats to staff or other inmates?		✓
Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?		✓
Does the inmate have any obvious physical handicaps?		✓

FOR THE OFFICER

Was the new inmate oriented on sick/dental call procedures?

This inmate was

✓ a. Released for normal processing

____ b. Referred to health care unit

____ c. Immediately sent to the health care unit.

D. Dunn

Officer's Signature

This form will be completed at receiving and will be filed in the inmate's medical jacket to comply with NCCH Standards.

HEALTH CARE UNIT
PATIENT INFORMATION SLIP

Draper

INSTITUTION

Martin, Marlon — NAME

225145 — NUMBER

Bm — R/S

Lay-in for _____ days from _____ to _____

(date)

_____ due to _____

(date)

Instructions: Work stop, lay-in due to T temp

Failure to follow the directions above may result in a disciplinary.

12/17/03

Date Issued

Dr. Sonnier DAustin

Signature

HEALTH CARE UNIT
PATIENT INFORMATION SLIP

Kilby
INSTITUTION

Martin, Marlon — 225145 — Bm
NAME **NUMBER** **R/S**

Lay-in for _____ days from _____ to
(date)

_____ due to _____
(date)

Instructions: Come to OPC at 6am weekdays and westward on the weekends x 7days

Failure to follow the directions above may result in a disciplinary.

12/13/02
Date Issued

V. O. A. Lowery CRNP
Signature
R. Hanes for

F-53

PRISON HEALTH SERVICES INCORPORATED

Special Diet Request

Inmate's Name: MARTIN, MARLON #225145 Date: 6/29/06

Housing Location: STOTAN

Type of Diet: DOUBLE PROTEIN DIET

Start Date: 6/29/06 Stop Date: 6/28/07

Special Instructions (if needed):

Date Requested: 6/29/06 Signature: [signature]

60130 (10/89)

(White - Kitchen Copy, Yellow - Patient File Copy)